PATIENT SATISFACTION WITH CARE PROVIDED BY ASSOCIATE DEGREE NURSING STUDENTS

BY

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Dedicated to

my parents
Olive and Clifton Davis

and my four children

Vicki Lee
Kathryn Shirley
Leslie Jo
Scott Davis

who supported and loved
me through it all.

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By

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This study was designed to assess patient satisfaction with care by associate degree nursing students using the Patient Rating Scale developed in an earlier study of satisfaction with care by baccalaureate nursing students. A secondary purpose was to test the scale as an indicator of patient overall satisfaction with nursing care.

Thirty-nine associate degree nursing students were rated by themselves, their instructors and 77 patients. The overwhelming finding was highly positive ratings for student clinical performance.

Student ratings by the three groups were correlated with each other and with the nursing gradepoint average (GPA). Nursing GPA did not relate significantly to student self-ratings. However, a correlation between GPA and ratings by instructors and patients was found and indicated that as nursing GPA increased, ratings did also.

The variables of patient age and educational level did not show a significant relationship to patient satisfaction with nursing care.

But a significant relationship was found between number of hospitalizations and satisfaction with nursing care. Patients with three or more hospitalizations showed greater satisfaction with nursing student performance than those with two or fewer hospitalizations.

Students were rated lowest by all three groups on diet teaching and giving patients self-care information for use at home. Students rated themselves low on performing technical skills.

This instrument could be a useful addition to formative and summative evaluations in programs of nursing. Refinement of its three subscales would give the scale additional value as a diagnostic tool in assessing nursing student clinical performance. At present it is a valid measure of patient overall satisfaction with nursing care.

CHAPTER I

INTRODUCTION

Nursing evolved from a need to be responsive to the human condition known as the wellness-illness continuum of people. Nurses adopted the twin principles of caring and curing in responding to the needs of their consumer, the patient. A newly developing response to consumer needs, as an outgrowth of the accountability movement of the past decade, is patient evaluation of nursing care (Kitchen, 1979; Kirchhoff, 1976; Teetsel, 1975; Watson, 1979; Woolley, 1977).

Accountability is the major pressure on nursing today: Accountability to the student, the patient, society (McMullan, 1975). Accountability requires nursing to look closely at what the profession is doing, how it is achieving its professional goals, and how attainment of its goals can be expedited. The demands for accountability and consumer rights have been increasingly integrated into our present society (Golembiecki and Etherington, 1979). The consumer/accountability movement has developed for a number of reasons: increased technological and medical advances with concomitant elevated expectations; increased insurance coverage and wages that enable people to afford more health care; greater life expectancy that creates the need for more health care; higher educational achievements with a rise in desires and expectations as seen in the rising number of lawsuits involving the medical field; better communications making the public more aware of the availability of health services and, of major importance, the meteoric rise in health care costs (Califano, 1979; Hines and Wiles, 1980; Goodlad, 1979; Novello, 1978; Penland, 1979; Schofer, 1979; Shapiro, 1979). Every consumer is affected, directly or indirectly, by the high cost of health care and increasingly the public demands explanations for and input into policies that lead to the planning for and provision of health care (Jeffries, 1979).

Concern as to quality of nursing care increases (Bloch, 1975; Burke and Goodale, 1975; Epstein, 1977; Golembiecki and Etherington, 1979; Hattstaedt and Isaac, 1975; Kirchhoff, 1976; McMullan, 1975). Quality assurance is a major theme in nursing and evaluation of the quality of nursing care is an integral part of planning for nursing services. One result of this growing concern is increased recognition of the need for systematic and continuing evaluation of nursing performance (Burke and Goodale, 1975). Evaluation of nursing care has historically been sought from nursing educators and students (Woolley, 1977). But obtaining evaluation data from clients of the health care system is a relatively new idea which has found its way into legislation affecting all groups involved in health care delivery, including nursing educators. For example, consumer input into the evaluation of baccalaureate nursing curriculum has been established by the National League for Nursing as among the criteria for accreditation of such programs (Watson, 1979).

Controversy exists over the involvement of patients in the evaluation of health care service. The major issue is similar to the question of student evaluation of faculty in post-secondary institutions in the past decade. Do consumers have sufficient knowledge and insight to give reliable and valid evaluation of services received? Coffman (1954) and

Costin, Greenough and Menges (1971) reported that well designed studies demonstrate that student ratings are reliable and can provide reliable and valid information on the quality of courses and instruction. Patient ratings of nursing students should serve a function similar to student ratings in higher education. Patients' wellbeing and confidence in their care may be related to how well they think the care is being delivered. The recipients of health care are surely in a unique position to provide information that is not available from any other source since they have the greatest opportunity for first hand observation of health care delivery (Watson, 1979).

Educators frequently suggest that students are and should be responsible for their own learning (Litwack, 1979; Palmer, 1967; Panos, 1979; Penland, 1979). Self-evaluation is one way of giving students an opportunity to look objectively at themselves and their performance. Self-assessment can enable students to recognize their own strengths and weaknesses (Bailey, 1978). Self-evaluation can increase student motivation to learn and can also increase students' ability to assess consumer needs (Johnson, 1979). Panos (1979) expressed the idea that "as students become involved in learning, participation in clinical evaluation follows naturally" (p. 21). Mitchell (1979) found that "student estimates of ability, luck, interest and effort are all significantly related to gradepoint average" (p. 135).

Evaluation is inseparable both from learning and from the care of patients (Pollert, 1975). Evaluation remains a major problem in nursing education (Forbes and Nelson, 1979) and no good evaluation is available (Woolley, 1977). New concepts of and approaches to evaluation are needed. Patient evaluation of nursing care is such a new approach.

The guardian of the health care system was first religion, then medicine and is now the consumer. The nursing profession has the opportunity to relinquish its past role of passivity, of waiting to be asked for input, and to participate with the consumer in arriving at decisions in national health planning. Nurses and consumers can work together to educate each other for leadership in health planning. Nurses can demonstrate administrative principles, develop models of health care delivery, and identify methods of planning and evaluative services and interpersonal skills. Consumers can educate nurses by sharing information related to what the public wants from the system, what appears to be missing in the system, how consumers expect to be treated, and how much they are willing to pay (Stanhope, 1979).

One way of working together is to give patients the opportunity to evaluate the care they recieve, particularly that from new participants in the delivery of health care. In nursing, this would be students in nursing education. Patients may not always be able to evaluate students' skills, but they know how they feel about the care they receive (Kitchen, 1979). And educators have an obligation to the patient who is both receiver of and participant in nursing care performed by the student (Golembiecki and Etherington, 1979). Popham (1978) stated that American health professionals are engaged in establishing measurable standards of practitioner professionalism. Surely the input of clients would be of value since they know what they want (Sparrow, 1978). And evaluation should provide a growth opportunity for nurses and nursing. In addition, consumer participation in the planning, management and evaluation of health care programs is considered a method for increasing provider responsiveness to the goals and needs of user services (Metsch and Veney, 1976).

Watson (1979) designed a 19-item, paper and pencil Patient Rating Scale to elicit patient ratings of nursing students. The instrument was developed and tested with 52 Iowa senior baccalaureate nursing students and 96 patients. Watson recommended using the Patient Rating Scale with students in different types of nursing programs. Though she considered a number of variables in the patient population she studied, she found the only significant variables to be age and educational level.

Purpose of the Study

The purpose of this study was to determine the satisfaction patients feel with care by associate degree nursing students using the Patient Rating Scale developed in Watson's (1979) study of satisfaction with care by baccalaureate nursing students.

The researcher related the concepts of accountability and consumerism, instructor evaluation, and self-evaluation to patient ratings of student performance and to student self-assessment. The research was designed to show the relationship between patient age, educational levels, and number of previous hospitalizations as variables that influenced their ratings of nursing students. Watson (1979) found a statistically significant difference between those age groups below 40 and those above 40. This finding coincided with Morgan's study (1974) which found that patients under 40 expressed more dissatisfaction with care than did older patients. A statistically significant difference was also found between those with post-secondary education and those with less than that. This corresponded with findings of DeWolfe, Barrell and Cummings (1964) that the better educated consumers were less content with hospitalization.

Review of the Literature

Consumerism became a major movement in the decade of the 1970's. It had its origins in the accountability pressures that came to bear upon all aspects of life, particularly on education and medicine (Goodlad, 1979; Hines and Wiles, 1980). These two fields had remained relatively free of accountability to the recipients of their services, but with the public outcry against much of education and the sharp increase in litigation against the medical profession, changes occurred.

Evaluation is one way of answering to the cries of accountability. And evaluation of the present system of health care delivery, including nursing care, is a logical starting point for upgrading the system to meet present needs, including accountability and consumer input. Evaluation is best done with multiple raters using the same set of evaluation criteria (Litwack, 1979). Evaluation is also improved upon when different levels of evaluators are used (Thornton, 1980). For these reasons, a summary of findings of the evaluation of nursing students' clinical performance by instructors, by student self-assessment, and by the consumer, the patient, is presented. In addition, the issues of consumerism and accountability are reviewed.

Consumerism and Accountability

Consumerism is perhaps the most powerful force in our society today (Marshall, 1979). Consumers know what they want, including an active role in seeing that their needs are met. President John F. Kennedy, in a 1962 message to Congress, outlined four consumer rights: 1) right to safety, 2) right to be informed, 3) right to choose, and 4) right to be heard (Novello, 1978). Consumer participation in the planning and management of health care is prescribed as a method for increasing provider responsiveness to the goals and needs of user services (Metsch and Veney, 1976). Government has mandated that consumers be included in health care planning in many areas. However, meaningful participation is difficult to achieve and monitor. The fact that providers and consumers have different objectives necessitates diligent communication for true cooperation.

Accountability calls for collection of information about a number of aspects of an endeavor. As Popham stated, it would seem that client satisfaction is an important ingredient of what one should aspire to promote (reported by Bronstein, 1979). Nursing has an obligation to the patient, the consumer in the health care setting, the individual who receives as well as participates in the student's nursing care (Golembiecki and Etherington, 1979). The Patient's Bill of Rights of the American Hospital Association expresses the need for the respect of patients. And the chief reasons for growth of consumer participation in health care services are the quality of performance and of services and rising costs. Improving the quality of performance is the most constructive consumer-oriented program that can be undertaken. Taylor wrote that today's patients resent being treated as if they are incompetent. They want to understand what is happening to them, and believe they would respond more rapidly to treatment if permitted to become active participants (Sparrow, 1978).

External pressures from the public are beginning to have an effect on the accountability in health professionals' education (Bronstein, 1979). So American health professionals are currently engaged in establishing measurable standards of practitioner proficiency. These initiatives, to assure competency, have been stimulated in large measure by the health professions themselves, but also by a public clamor for higher quality of health services (Popham, 1978).

Soliciting the opinions of patients about the care they recieve is one way of checking the satisfaction of health care consumers. Kogan and Jackson (1961) found that patients' opinions of nurse, patient and physician roles were more uniform than the opinions of other subjects. Therefore patients would seem to be a good source of information about patients' expectations of care from nurses, physicians and allied health personnel. Patients usually have something, either good or bad, to say about their nursing care. So it should be enlightening to tap this source of information. Kirchhoff (1976) asked 11 intensive care unit patients about the quality of nursing care they received. He was surprised at the number of negative comments. Since this kind of unit has a high nurse-patient ratio, one would expect patient needs and expectations to be well met. Marram (1973) found that to nurses, patient evaluations were important. However, patient evaluations carried little weight in the hospital power structure.

The validity of patient evaluations of nursing care could be questioned in light of the study by Nehring and Geach (1973). Patients were reluctant to make negative or critical comments for fear of reprisals, sometimes in the form of the withholding of care. This can be a threat to patients, who are virtually powerless in the hospital setting. Consumers feel the "good" patient is one who cooperates with health personnel, listens to and accepts their judgments and decisions about the care, and generally accepts a dependent role. But "new" consumers add another dimension to that of the "good" patient--active involvement in their own care, including "self-help" when appropriate (Glazer, 1981). Though patients may not be able to judge if nursing students do procedures correctly, they are aware of their feelings about these procedures (Kitchen, 1979), and feelings have long been recognized as a vital part of any situation.

Two official organizations representing nurses, the National League for Nursing (NLN) and the American Nurses Association (ANA), have made statements recognizing and advocating consumer participation in health care. In 1970 the ANA adopted a resolution calling for consumer representation in that body. The NLN (in 1959) published a Patients' Bill of Rights. This document stated in part:

1. Nursing personnel who care for (a patient) are qualified through education, experience and personality to carry out services for which they are responsible.

2. Nursing personnel will be sensitive to (patient's) feelings and responsive to (their) needs (Benson, 1977).

Recognition by the nursing profession that the patient does and should have an active part in health care has resulted in a renewed concern over the quality of nursing care. Emphasis upon evaluations of all types is the outcome of this concern. The method of charting advocated is increasingly objective and yet more inclusive, including both physical and mental assessments. Considerable time and energy are expended by nursing faculties in giving specific, objective, well documented evaluations of students in the clinical performance. Official statements of nursing practice responsibilities clearly make nurses responsible to the consumer for their actions. The nurse can no longer hide behind the protection of the physician. Increasingly, schools of nursing and nursing services focus on the needs of consumers (McMullan, 1975).

A new responsiveness to consumers resulted in studies of patient satisfaction with nursing and medical care (Marram, 1973; Nehring and Geach, 1973; Hart and Bassett, 1975; Morgan, 1974; Teetsel, 1975). The common theme of these studies was a need for a better understanding of what patients (consumers) desire and see as important in health care delivery and to improve the quality of care given. Since patients do form opinions about the care they receive, and since health care professions are responsible to consumers for care given, a natural progression for improvement of this care is to incorporate patient evaluations into the education of health professionals. This would give health care personnel incentive and feedback from the beginning of their professional careers as to how well they are meeting the needs of consumers. This would also inculcate into new professionals a willingness to bend to the needs of the group to whom they render services. A continuing dialogue could ensue between health professionals and consumers so that consumers would have an ongoing, active role in health care planning and delivery.

Instructor Evaluation

Accountability is now a condition of life in American higher education and will continue to be a major issue for the foreseeable future (Hines and Wiles, 1980). In general, accountability means a responsibility to someone to fulfill specified criteria. Bruce (1976) outlined four components of accountability in nursing education. First, there must be an agreed upon set of goals in the professional area for which practitioners are to be prepared. Second, from these goals standards can be set with specific practitioner performances. Third, these performances provide the structure for the teaching component. Finally, assessment of performance is needed in both controlled and field situations (Watson, 1979).

Nursing educators stand at the gate to evaluation in nursing. They initiate future professional practitioners into the realm of quality of nursing care with concomitant need for evaluation of its effectiveness. Bloch (1975) stated, "The effectiveness of care . . . is the ultimate validator of the quality of care. The validity of all other phenomena as indicators of quality depends ultimately on the relationship between these phenomena and the achievevement of health and satisfaction" (p. 20). The intrinsic difficulty of standardizing the evaluation content for nursing is the uncontrollable factor in the clinical arena (Pearson, 1975). Nurse educators deal not only with the uniqueness of individual students, but also with a variety of well educated and unique health care consumers who have high and perhaps specific expectations of nursing care.

Nursing educators are responsible to three distinct groups in giving evaluations: 1) the student, 2) the patient, and 3) future employers of the student. So they need tools that measure essential nursing skills objectively and accurately, that focus on what nurses do as well as on what they know, and that give the nurse the opportunity to demonstrate clinical competence (Rogers, 1976). The majority of nursing faculty feel that the most important area of educational assessment is clinical evaluation. At no other time in their professional nursing careers will their ability to give safe, competent care be as carefully evaluated as during their experience as students (Litwack, 1976). The primary purpose of evaluation is communication, the desired result being improvement in the evaluatee (Marcotte, 1978). Ideally, a well understood method with clearly defined criteria is used in a situation of mutual trust and respect between evaluator and evaluatee. This ensures greatest effectiveness for an evaluation.

In spite of a history of clinical evaluation in nursing education, there remains no one agreed upon best method. Some evaluators feel nursing faculty would be less frustrated if society admitted, or faculty were allowed to admit, that evaluation is intuitive and subjective, as well as objective (Woolley, 1977). However, objective, measurable criteria are popular today and subjective or intuitive evaluations are frowned upon for a variety of reasons. Effective clinical evaluation remains the number one problem for nurse educators, with no clear answers, but the possibility of many creative and unique approaches (Forbes and Nelson, 1979).

One approach seen repeatedly in the literature and in nursing education practice is a checklist of specific competencies (Hattstaedt and Isaac, 1975; Litwack, 1976; Grussing, Silzer and Cyrs, 1979; "Articulation of Competency Based," 1974-1975; Topf, 1969; Wandelt and Slater, 1975; Burke and Goodale, 1975). These checklists include desired competencies in technical skills, leadership and communication. Reilly asserted that clinical evaluations can be more vulnerable to values of the instructor than in any other evaluation experience (Lynch, 1978). And Bohning (1978) stated that evaluations based on subjective judgment are as much a reflection of the supervisor making the evaluation as the student being evaluated. Therefore, alternate modes of evaluation are needed. Some alternatives include multiple faculty evaluations, student self-assessment, peer evaluation and patient assessment.

Students learn from role models in the clinical area--the clinical instructor, the staff and peers. But what about the effects patients have on the learner? Certainly patients can and do promote, neutralize or inhibit learning by students. The critic, the nursing instructor as evaluator, examines the work of the student for quality and its effect on the patient. The goal is to provide effective feedback to the learner to facilitate and maintain compatibility between creativity and quality (Pearson, 1975). The evaluation must be based on specific and measurable objectives and successful behavior must be reinforced with positive feedback (Phillips, 1979). Students constantly provide data about their performance. The fact that evaluation is an ongoing process is at best frustrating and occasionally rewarding (Kitchen, 1979). But a consumer-rights oriented society wants assurance of quality nursing care. The nursing faculty as evaluators perform a key role for this society.

Student Self-Evaluation

Palmer (1967) defined clinical self-evaluation as something the student does through the use of two mediums: a teacher who cares, and a set of well defined clinical practice criteria. The instructor should be the person who stimulates student learning and encourages students to keep open, questioning minds. The evaluation of this process should provide growth opportunities for both student and teacher.

The reasons for self-appraisal are multiple. They include: 1) behavior is not permanently changed by fiat (or administrative edicts); 2) one behaves according to one's own perceptions of reality and individuals' perceptions of "reality" differ; 3) threat narrows perception and the ability to grow, and 4) there is no one model of a good teacher (Hartman, 1978). However, varying degrees of credibility are given to self-assessment, and good self-assessment is rarely simple (Bailey, 1978). Davis and Rand (1980) reported findings that were consistent with those of a study by Burke and Goodale (1975). The latter showed that grades generated by self-evaluation were overly generous and resulted in little agreement with instructor evaluation. Munster (1975) found no correlation between student and faculty evaluations of junior medical students, but there was more consistency in patients' evaluations of the students. Thines (reported by Johnson, 1979) felt student self-evaluation could be overrated since students were often not in a position to judge their own work. And Thornton (1980) did not view self-evaluation favorably. He reported that most studies showed individuals rated themselves higher than comparison groups rated them. He felt self-evaluation should be used carefully since evaluations might be different when supervisor and employee evaluations were compared. Bandura (reported by Levine, 1980) placed self-appraisal on a par with environmental influences and actual observation of the behavior itself.

A paper by Levine, Flory and Ash (reported by Levine, 1980) advanced the notion that self-assessment of skills, abilities, knowledge and job performance might yield valuable information. Levine et al. concluded that based upon the conflicting assessments of the value of self-evaluation, this process might or might not work. It would depend upon the judgmental process, the reaction of an individual to self-evaluation, and the accuracy of the self-observation, the major flaw being the lack of objectivity.

On the positive side, self-assessment has been shown to influence both internal and external mobility (Heneman, 1980). Palmer's study (reported by Panos, 1979) showed high positive correlation between teacher ratings and student self-ratings. And Panos expressed the belief that if the responsibility for learning belongs to students, then they ought to be encouraged to establish their own goals for learning and to determine the criteria for measuring attainment of those goals. Litwack (1979) felt that self-evaluation is an important input in overall evaluation. Students have an equal responsibility with faculty for meeting clinical objectives and assessing progress. Therefore, how students perceive themselves and on what they base their judgments is important. Students have a responsibility to self, to peers and to the profession they are entering. They should share in the responsibility for systematic, open and honest assessment of their own strengths and weaknesses. Comparing student and faculty evaluations will provide useful analyses of areas viewed differently. And though obtaining reactions from patients about the quality of care can be difficult, comparing student reactions to interactions with student self-assessments can help students gain a better picture of verbal and non-verbal messages they give patients.

Bailey (1978) suggested effective self-assessment fosters independence and self-direction. He agreed with Litwack (1976) that the advantage of both instructor-collected information and student self-feedback is that the two sources can be compared and congruity or incongruity determined. He also saw objectivity as the major obstacle in self-assessment.

Palmer (reported by Johnson, 1979) stated that students who used a device to determine their own grading would develop better self-understanding. Through this self-awareness they would develop a better perception of the needs of patients.

Johnson (1979) stated that self-evaluation helps students identify both clinical functions they are anxious about and those with which they are comfortable. Instructors cannot determine accurately students' feelings about a function. Only the students can evaluate their degree of comfort or anxiety. This makes self-assessment critical. Self-assessment also is less limiting to the learning environment and enables students to develop a more mature attitude toward self and work and to view achievements more objectively. This objectivity is carried over into increased ability to evaluate patient and/or employer needs. The process of self-evaluation means a risk of exposing the true self though, and some students are reluctant to take this risk. Annis and Perry (1977) reported that females demonstrated more feeling and more self-disclosure than males. One could also then question whether females are more likely to give more realistic self-evaluations.

Williams and Muehl (1970) and Mitchell (1979) showed that student estimates of self-concept, ability, interest and effort all had a significant relationship to gradepoint average (GPA). Students with high self-concept and those who gave high estimates of ability also had high gradepoint averages.

Involvement in self-initiated and self-planned evaluation can be fostered by self-assessment during educational experiences (Penland, 1979). Results of self-appraisal indicate this is a promising developmental approach to evaluation. Student self-evaluation is definitely an integral part of nursing education today. Dividends are increased self-assurance and self-actualization, more ability to assess both patients and self with greater accuracy, and a deeper, clearer understanding between student and instructor as well as a better self-understanding (Johnson, 1979). In addition, Meyer (1980) found that though self-appraisals tend to be generally high, this is not all negative. Increased self-esteem yields higher self-evaluations, which yields higher performance (Jako, 1980; Levine, 1980, Meyer, 1980). One way to foster high performance in future nursing professionals is to continue the use of student self-evaluation.

Definition of Terms

The following terms are used in this study as defined here.

Adult patient--any individual 18 years of age or older hospitalized at the hospitals used in the study.

Student--a student enrolled in a Level 3 medical-surgical nursing course at Valencia Community College.

Instructor--the instructor assigned to supervise the clinical experience in a hospital of a group of no more than 12 Level 3 students.

Nursing gradepoint average (GPA)--the gradepoint average the student has achieved in nursing courses, on a 4.0 scale.

Student ability--score received by the student on Patient Rating Scale in Appendix A.

Student skill--the ability of the student to perform commonly accepted nursing skills.

Patient occupation--the patient's vocation as reported by the patient on the patient demographic data form included in Appendix E.

Rating Scale--the 19-item Patient Rating Scale developed by Watson (1979) to be used by patients in evaluating care received from nursing students. Please see Appendix A.

Level 3--the third of four levels of courses through which a student must progress to complete the Valencia Community College associate degree nursing program.

Assumptions

1. Patients, students and instructors were honest and accurate in reporting on the Rating Scale.

2. No unusual events were occurring within the hospital or in the outside world that would have significant effects on the study.

3. Student assignments were made by chance with no correlation between student GPA and patient assignment.

4. Ratings by patients who did not complete the Rating Scale would not be significantly different from the ratings done by the patient sample.

5. There was no difference in the two groups that participated in the study in May and in September.

Hypotheses

This study was designed to assess patient satisfaction with nursing care by associate degree nursing students, using the Patient Rating Scale developed in an earlier study of satisfaction with care by baccalaureate nursing students. The hypotheses tested in the present study were as follows:

1. Ratings of nursing students by patients, instructors and self will have a positive correlation with nursing gradepoint average.

2. Ratings of nursing students by patients, instructors and self will have a positive correlation with each other.

3. The overall satisfaction with care given by nursing students will be assessed "very positive" by patients, instructors and students.

4. Student gradepoint average will have a positive correlation with overall patient satisfaction.

5. Patients 40 years of age and older will show a higher satisfaction with the care received from nursing students than patients younger than 40.

6. Patients with post-high school educations will show less satisfaction with the care received from nursing students than patients with only a high school education or less.

7. Patients who have had three or more hospitalizations will show more satisfaction with the care received from nursing students than those who have had fewer than three hospitalizations.

Limitations of the Study

1. Only students in the third of four levels (Level 3) of study in an associate degree program of nursing participated in the study.

2. The patient sample was drawn from general medical-surgical patients who were physically and/or mentally able to complete the Rating Scale.

3. Only instructors from Valencia Community College Level 3 participated.

4. Only general hospitals in a large metropolitan area were used in the study.

CHAPTER II

METHODOLOGY

This chapter explains the selection methods for the student and patient samples, and the instructors who participated. It also reviews the Rating Scale used and the procedure used to administer it to patients, students and instructors.

The Nursing Student Sample

The student sample in this study was drawn from students enrolled in Level 3 nursing courses at Valencia Community College, Orlando, Florida--a nonrandom convenience sample, just as in Watson's study. This program was readily accessible to the investigator. It was also a different type of nursing program from the baccalaureate program studied by Watson (1979). Using an associate degree program followed Watson's suggestion that the scale be used with students from different types of programs. Valencia is accredited by the National League for Nursing (NLN), the accrediting body for nursing programs, therefore meeting the same standards as other NLN accredited associate degree programs in the United States. Level 3 courses consist of one critical care course, one pediatric course and two general medical-surgical nursing courses. Students were chosen from Level 3 because they would have had some prior nursing courses. In addition, students selected were those in the general medical-surgical nursing courses because in the judgment of the faculty, the hospital administration and this investigator, patients in these areas would be more suitable subjects for this study. Students in Level 3 also care for at least two patients most of the time. This would permit obtaining multiple patient ratings.

Eighty-two students were enrolled in the two general medical-surgical nursing courses, NUR 2221C, Nursing Care of Adults with Motor and Sensory Deprivation, and NUR 2222C, Nursing Care of Adults with Problems Related to Maintenance of Nutrition, Elimination and Regulatory Mechanism. When approached by their faculty, all students agreed to be a part of the research. However, because of various rotations in the community or in critical care areas of the hospital, only 39 students who were present in the hospital during the two-week periods of data collection in May and in September made up the student sample. They were assigned to six medical-surgical instructors. The number of patient ratings obtained on these 39 students varied from one to four per student. The reasons for this variation are discussed below under the patient sample.

Self-ratings were done at the end of the two-week data collection periods. Students were asked to fill out a Patient Rating Scale (Appendix A) and also a data collection sheet with their age, sex, and grades for nursing theory courses (Appendix B) so their nursing GPA could be calculated by the investigator. They were assured their ratings would not influence their grades and that they as individuals would remain anonymous. Students were instructed to fill out the scale as if they were the patient and were evaluating the care they had received from a nursing student. Data were collected during the fourth and fifth weeks of seven and one half weeks rotation.

Patient Sample

Patients who participated in this study were selected as a nonrandom convenience sample from inpatients of seven general hospital medical-surgical units. Nursing instructors from Valencia Community College assigned to supervise the clinical experience of nursing students selected the patients on the basis of their physical and/or mental ability to complete the Rating Scale. This occurred on Tuesday, the first clinical day of the two-week data collection periods. The instructor explained that the purpose of the study was to ascertain the satisfaction patients feel about the care they receive from nursing students. Patients were assured they would remain anonymous, their ratings would not affect the grades of the students, and their participation was voluntary. Patients were also told the hospital had granted permission for the study to be done.

If the patient agreed to participate, the instructor left information about the study, the Rating Scale and directions for its completion (Appendixes A and D) and a demographic data sheet for the patient to complete (Appendix E). Patients were instructed to leave the rating scale at the nursing desk if they were discharged before the end of the two-day period. Those scales were not included in the study. Though the patients had the scale in their possession during the two-day care period, they were instructed to complete it after the care by the students was finished. The instructors collected the completed Rating Scales at the end of the clinical day on Wednesday.

Instructor Sample

The six instructors who participated in the study were medical-surgical nursing faculty from Valencia Community College. Each was assigned to supervise the clinical experience of no more than 12 nursing students. Instructors rated only those students who were a part of their own clinical group. Rating was done at the end of the two-week data collection periods.

The Rating Scale

The Rating Scale used in gathering data for this study was developed by Carol Ann Mason Watson at the University of Iowa during the academic year 1978-79 as her doctoral research. She used the baccalaureate nursing program at Grand View College, Des Moines, Iowa, as the data base for her study.

Watson designed the instrument as a tool for patients to evaluate the process of nursing care provided by nursing students. Areas of nursing care for which patient evaluation seemed reasonable were identified from objectives of the nursing program. Watson reviewed other scales in use for evaluating nursing care and then developed her own rating scale.

The Rating Scale considered three aspects of nursing student performance: interpersonal skills, leadership skills and technical skills. She pilot tested the Rating Scale with two groups of individuals, both hospitalized and non-hospitalized adults. Finally, the instrument was revised again with input from the pilot study and the nursing faculty of Grand View College.

Watson used a data collection plan that has been implemented in this study. Nursing students were rated by patients, instructors and self on the quality of care given to patients. The three subscales, however, showed low rater reliability, non-discrimination among the three attributes and limited variability of the ratings. Watson concluded that it was difficult to demonstrate uniqueness of any subscales. She recommended that the instrument be used only as a measure of overall patient satisfaction with nursing. That was the context in which the scale was used in this study.

Watson also recommended that a study be conducted in a different geographic area; that a different type of nursing education program be used; that the researcher use the instrument as a measure of one variable only, overall patient satisfaction with care by nursing students, even though the instrument was designed originally with three subscales; and that patients hospitalized in various institutions be used. This study used students in an associate degree nursing program, in a southern setting, with patients from four hospitals, and viewed the scale as a measure of patient satisfaction with care by nursing students.

Though the instrument itself was used as a measure of patient satisfaction with care received from nursing students, item 19 of the scale was designed specifically to measure overall satisfaction with patient care. Item 19 was worded: "I am completely satisfied with the nursing care I received. It met my needs." "I thought the nursing care I received was adequate, but it was not all that I expected." "I am not pleased at all with the nursing care I received. It did not meet my needs." All items were rated on a continuum. Participants in the study marked according to a point along the line between or nearest to the three statements that best described their opinions. Ratings for the first 18 items and item 19 were considered separately both in stating the hypotheses and in statistical analysis.

Variables

Watson (1979) found that patient age and educational level made a difference in patient ratings. A statistically significant difference was found between those age groups below 40 and those 40 and above. This finding coincided with Morgan's study (1974) which found that patients under 40 expressed more dissatisfaction with care than did older patients. DeWolfe et al. (1964), Morgan (1974) and Petroni (1969) showed that younger, more highly educated patients were more critical of the care they received. A statistically significant difference was found between those with post-secondary education and those with less that that. Morgan (1974) also found that patients with multiple hospitalizations were less critical of their care than patients admitted for the first time. This study looked at age, education and number of hospitalizations as variables relating to patient satisfaction.

The ratings were compared to nursing GPA because nurse educators believe theory grades and clinical performance should be positively related. Dubs (1975) reported, however, that theory grades were not good predictors of clinical performance, but that clinical grades were good predictors of on-the-job performance. Watson did not find a correlation between nursing GPA and patient ratings.

Controls

Nurses are usually seen by patients as being dutiful, subservient and obedient (Willman, 1976). They are sometimes viewed as being more patient advocates than other health professionals. They also give very personal care to patients. All these factors may operate to give a type of halo effect, or a generally positive response to patient ratings of nurses. Several controls were used in this study to offset that effect.

First, patients were told that they were to evaluate the performance of nursing students only. This was emphasized both on the personal visit and in written instructions. A second precaution was that during the data collection period patients were checked to verify that each could identify the nursing student assigned. Third, the nursing student wore a distinct uniform, one that was different from that of other nursing staff. Fourth, instructors introduced themselves as such and patients saw them function in roles that differed from those of other members of the nursing staff.

Statistical Methodology

The Pearson product moment coefficient of correlation was used to test the relationship between nursing GPA and rating; the ratings among the three groups; nursing GPA and overall satisfaction as measured by item 19 on the scale; and the relationship among ratings of the three groups and item 19 on the scale. The Pearson product moment was chosen because it is the most commonly used correlation index. It summarizes the relationship between two continuous variables and may be used for prediction.

The _t_ test of significance was used to test the relationship between the variables of patient age, educational level and number of hospitalizations and patient satisfaction with nursing care. The _t_ test was chosen since the sample size was small and since it is a reliable index to find the significance of the difference between the means of two independent samples.

CHAPTER III

RESULTS AND CONCLUSIONS

This chapter presents statistical analysis and discussion of the results of the ratings of the three groups: students, instructors and patients. Tests of the hypotheses are discussed and findings are compared with Watson's study (1979). Results of an item analysis are presented and discussed as well as some supplementary findings.

Tests of the Hypotheses

Hypothesis 1 stated that the nursing GPA of the student would have a positive relationship to student, instructor and patient ratings. A Pearson product moment correlation was run on the GPA and totals of the first 18 items on the Rating Scale (Table 1). A mean rating was used for students with more than one patient rating. This test showed a .1170 correlation (p=.239) between student self-ratings and GPA; a -.3742 correlation (p=.009) between instructor ratings and student GPA; and a -.2967

Table 1

Pearson Correlation Coefficient with Student
Nursing Gradepoint Average
18 Items

	Coefficient	Probability
Student	.1170	.239
Instructor	-.3742	.009
Patient	-.2967	.033

correlation (p=.033) between patient ratings and student GPA. These coefficients indicate that GPA did not relate significantly to overall student self-ratings. However, GPA did relate to overall instructor and patient ratings on the 18 items. As student GPA increased, so did the ratings of instructors and patients. Nursing educators have long held and acted upon the belief that the better classroom student is also the better provider of nursing care in the clinical setting. The patient and instructor ratings in this study tend to bear this out.

Hypothesis 2 stated that the correlation among the ratings of the nursing students by patients, instructors and self would be positive. All groups rated students very positively (Table 2, p. 31). Students rated themselves 68.8% very positive, instructors gave 70.1% very positive ratings, and patients rated students 74.9% very positive on the first 18 items of the rating scale. A Pearson correlation (Table 3, p. 32) showed students self-ratings were negatively correlated with instructor ratings (-.0838, p=.306) but were better correlated with patient ratings (.2609, p=.054). Instructors are apparently looking for different specific qualities of care than students or patients, but were satisfied with the overall care given by the associate degree nursing students who participated in this study. Since patients gave more positive ratings of student performance than did instructors, this suggests that those responsible for supervising the care may be less satisfied with the care given than those receiving the care. Such a difference is healthy for any group, for it assures a continuing scrutiny of services rendered and a continuing high standard of quality.

Table 2
Frequency Data--Very Positive Ratings
All Groups by Item

Item	Students Number	Students Percentage	Instructors Number	Instructors Percentage	Patients Number	Patients Percentage
1	33	84.6	27	69.2	63	80.8
2	35	89.7	29	74.4	65	83.3
3	29	78.4	27	69.2	56	80.0
4	25	69.4	28	71.8	47	74.6
5	29	74.4	29	74.4	59	76.6
6	27	69.2	29	74.4	62	81.6
7	35	89.7	31	79.5	69	89.6
8	22	61.1	24	61.5	39	61.9
9	30	78.9	27	69.2	48	65.8
10	24	66.7	25	64.1	53	72.6
11	12	34.3	11	31.4	28	49.1
12	18	51.4	17	51.5	28	52.8
13	34	87.2	30	76.9	66	88.0
14	27	71.1	30	76.9	50	72.5
15	32	82.1	28	71.8	65	90.3
16	17	43.6	23	59.0	54	73.0
17	20	51.3	23	59.0	57	74.0
18	16	41.0	22	56.4	57	76.0
19	25	65.8	27	71.1	65	86.7
Mean		68.8		70.1		74.9

The high ratings showed all three groups basically satisfied with the quality of care given.

Table 3
Pearson Correlation Coefficient
Ratings on 18 Items

	Coefficient	Probability
Student vs Instructor	-.0838	.306
Student vs Patient	.2609	.054
Instructor vs Patient	.1206	.232

Hypothesis 3 stated that the overall satisfaction with care given by the associate degree nursing students, as measured by item 19 on the Rating Scale,would be assessed as very positive by patients, instructors and students. The mean item 19 ratings (Table 4) revealed that student self-ratings were 65.8% very positive; instructor ratings, 71.1% very positive; and patient ratings, 86.7% very positive. Overall very positive ratings were 77.5%. Patients rated students higher on this direct question of satisfaction with overall nursing care than they did on all

Table 4
Mean Item 19 Ratings

	Very Positive Percentage	Positve Percentage	Neutral	Mean
Student	65.8	28.9	5.3	1.395
Instructor	71.1	26.3	2.6	1.358
Patient	86.7	6.7	6.7	1.200
Overall	77.5	17.2	5.3	1.278

but two of the other 18 individual items. This suggests that in spite of variations on individual items, patients were very satisfied with care received from these community college nursing students and are in fact the most satisfied of the three groups, as measured by item 19.

Overall satisfaction with the care received by the patients in this study (item 19) correlated positively with ratings of the other 18 items (Table 5). The total of the first 18 items of student self-ratings with item 19 gave a Pearson correlation of .5487 (p=.000). Instructor total 18 with item 19 gave a correlation of .7653 (p=.000), while the patient total 18 with item 19 correlation was .6355 (p=.000). While the student ratings had a lower correlation between item 19 and the total for the other 18 items, ratings of all three groups had a positive correlation between the overall satisfaction as measured by item 19 and the total for the other 18 items. Thus, degree of satisfaction with overall nursing care was strongly related to positive ratings of care on the first 18 items. The lower correlation for students may have been due to the homogeneity of their very positive ratings.

Table 5
Pearson Correlation Coefficient
Item 19 with Total of 18

	Coefficient	Probability
Student	.5487	.000
Instructor	.7653	.000
Patient	.6355	.000

Hypothesis 4 stated that student GPA would have a positive correlation with overall satisfaction with nursing care as measured by item 19 on the scale. A Pearson correlation for this reveals a .1046 correlation (p=.266) of student ratings with their GPA (Table 6), but a -.0279 correlation (p=.406) with patient ratings and a -.3666 correlation (p=.012) with instructor ratings. This is basically the same finding as that generated for Hypothesis 1, that as the student GPA went up, so did ratings by instructors and patients. Student ratings were not significantly related to GPA. This suggests students have a very favorable opinion of the nursing care they give, regardless of their classroom GPA. This may be somewhat unrealistic in view of the instructor and patient ratings. Instructors could be influenced by awareness of achievement of students in the classroom, but patients had no information about nursing student GPA. The fact that the findings of Hypotheses 1 and 4 are similar provides additional evidence that students who are more successful in theory also give better clinical care.

Table 6
Pearson Correlation Coefficient
Item 19 with Gradepoint Average

	Coefficient	Probability
Student	.1046	.266
Instructor	-.3666	.012
Patient	-.0279	.406

Hypothesis 5 stated that patients 40 years of age and older would show a higher satisfaction with the care received from nursing students than patients less than 40. Minimal differences were found both for the total of 18 items and item 19. A *t* test showed that the differences were not significant (Table 7 and Table 8, p. 36).

Table 7
t-Tests of Significance: Patient Age, Educational Level and Number of Hospitalizations with Total of 18 Items

AGE	Mean	SD	SE	df	t	P
40 and below (N=37)	1.326	.238	.038	75	1.11	.269
Above 40 (N=40)	1.262	.261	.042			

EDUCATIONAL LEVEL	Mean	SD	SE	df	t	P
High school and below (N=46)	1.292	.242	.036	75	.16	.880
College/graduate school (N=31)	1.283	.263	.047			

NUMBER OF HOSPITALIZATIONS	Mean	SD	SE	df	t	P
Two or less (N=42)	1.341	.233	.035	75	2.18	.030
Three or more (N=35)	1.219	.256	.045			

Hypothesis 6 stated that patients with post-high school education would show less satisfaction with the care received from nursing students than patients with a high school education or less. Some differences were found, but a *t*-test showed they were not significant (Tables 7 and 8).

Hypothesis 7 stated that patients with three or more hospitalizations would show more satisfaction with the care received from nursing

Table 8
t-Tests of Significance: Patient Age, Educational Level and Number of Hospitalizations with Item 19

AGE	Mean	SD	SE	df	t	P
40 and below (N=37)	1.211	.577	.094	72	.13	.900
Above 40 (N=40)	1.194	.525	.087			

EDUCATIONAL LEVEL	Mean	SD	SE	df	t	P
High school and below (N=46)	1.133	.457	.068	72	-1.36	.177
College/graduate school (N=31)	1.310	.660	.123			

NUMBER OF HOSPITALIZATIONS	Mean	SD	SE	df	t	P
Two or less (N=42)	1.214	.565	.087	72	.21	.837
Three or more (N=35)	1.186	.535	.095			

students than those with fewer than three hospitalizations. A t-test showed no significant differences in ratings of item 19. But there was a significant difference at the .05 level (Table 7) for the total of 18 items. Patients with three or more hospitalizations gave higher ratings for student performance on individual items than patients with two or fewer hospitalizations. They are less idealistic about nursing care.

The lack of significant differences in the variables of age, educational level and number of hospitalizations with item 19 could have been a function of the small size of the sample or a reflection of the lack of variance in the patient ratings, since patient ratings were consistently high.

Comparison of Findings with Watson's Study

Since this study is based on one done by Watson (1979), a comparison of findings for the two studies is pertinent. Watson found that baccalaureate students received very high ratings from patients, instructors and self. In Watson's study, patients rated students higher on overall satisfaction than instructors did or than students rated themselves. Findings of this present study of associate degree nursing students are similar. Other patient evaluation studies have reported high ratings of health care personnel in general and of nursing in particular (Hart and Bassett, 1975; Moore and Cook-Hubbard, 1975; Morgan, 1974). Patients generally rated their health care services very positively regardless of who rendered the care. Students and instructors did the same. A major theme in all the ratings was the issue of patient satisfaction. This attribute seemed related to the strength of positive responses, and indeed was perhaps the major factor influencing patient perceptions.

The ratings in this study should accurately portray Valencia Community College associate degree nursing student performance and should be a true reflection of the nursing care given by that group. The high ratings would tend to show that these nursing students at Valencia are meeting the expectations and needs of consumers, their patients. The fact that instructors and patients gave higher ratings to students with high GPA would suggest that students who have higher classroom achievement give better clinical performance.

The Nursing Student Sample and Results

The sample of 39 students included 37 females and two males. The age range was 19 to 50 years, the median being 25. This is similar to the reported national mean of 27 years for associate degree nursing students. The majority of the students (69.2%) were 20 to 29 years old. Twenty students (51.2%) were 20 to 25 years of age. Four students were 19 years old; one was 50. Seven students were more than 30 years old. The mean nursing GPA was 3.05. Students did not receive a separate grade for clinical, but had to achieve a satisfactory evaluation in clinical to pass a course. They were in the clinical area two days a week, Tuesday and Wednesday.

All student self-ratings were used. Of the 39 students, 33 answered the first 18 items. Thirty-eight answered item 19. Throughout the scale, students rated themselves high, 68.8% giving themselves a very positive rating on all 19 items (Table 2). The mean self-rating was 1.379 (Table 9, p. 39). On item 19, designed to summarize overall satisfaction with nursing care, students again consistently rated themselves high, 65.8% very positive, with a mean of 1.395 (Table 4), the scale being one for very positive and five for very negative.

These high ratings are a desirable outcome of this study and should represent a mastery level of performance. However, other factors may also have been operating that influenced the ratings. To be admitted to the nursing program students must have at least a 2.0 GPA, and most

Table 9
Average Score on 18 Questions
Student Self-Ratings

Rating	Frequency	Adjusted Frequency Percentage	Cummulative Frequency Percentage
1.00	8	20.5	20.5
1.05	1	2.6	23.1
1.11	1	2.6	25.6
1.16	1	2.6	28.2
1.18	1	2.6	30.8
1.21	3	7.7	38.5
1.22	1	2.6	41.0
1.28	1	2.6	43.6
1.33	1	2.6	46.2
1.36	1	2.6	48.7
1.37	1	2.6	51.3
1.39	2	5.1	56.4
1.40	1	2.6	59.0
1.42	1	2.6	61.5
1.50	2	5.1	66.7
1.52	1	2.6	69.2
1.56	1	2.6	71.8
1.58	1	2.6	74.8
1.63	1	2.6	76.9
1.67	2	5.1	82.1
1.72	1	2.6	84.6
1.73	1	2.6	87.2
1.74	2	5.1	92.3
1.78	1	2.6	94.9
2.06	1	2.6	97.4
2.10	1	2.6	100.0

Mean=1.379 Standard Error=.049 Standard Deviation=.305

are admitted with a GPA higher than 2.0. Successful students tend to have higher self-esteem and self-confidence than non-successful students (Heneman, 1980). Second, Valencia students must make at least a "C" on each nursing course to remain in the program, and may repeat each course only once. This would contribute to student self-confidence. The knowledge that their performance was being evaluated in a special way could have caused students to rate themselves more highly than they might have otherwise. Socialization to the role of the nurse is a part of nursing education. Since students must successfully complete at least two nursing courses to enter Level 3, they had to have demonstrated this socialization to the nurse role with some degree of consistency. Possibly, all 39 of the students provided high quality nursing care. Tables 2 and 7 show that students' self-scores were very positive and showed little variability. But the students' self-scores are consistently lower (68.8% very positive) than the scores given by their instructors (70.1% very positive) or by patients (74.9% very positive). Students were more critical of themselves than were either instructors or patients. This tends to agree with other studies which found that students were usually accurate in their self-assessment (Benton, 1980; Panos, 1979). Students seem to have even higher expectations of themselves than either patients or their instructors.

The Instructor Sample and Ratings

The six instructors rated 33 students on the first 18 items and 38 students on item 19 of the Patient Rating Scale. The latter omission may have been due to oversight. The average rating was high: instructors gave students 70.1% very positive ratings on all 19 items (Table 2). On item 19, the measure of overall patient satisfaction with nursing care, instructors again gave students high scores, 71.1% very positive, with a mean of 1.358 (Table 4). Instructors gave 53.8% of the students overall ratings on the first 18 items of 1.26 or more with a mean of 1.433 (Table 10, p. 42). No instructor ratings were below neutral.

Instructors rated students very positively, but lower than patients rated them, and yet higher than students rated themselves. Several factors may have contributed to this. First, instructors feel a responsibility for the quality of care given to patients by students. They are responsible under the law not only for their own actions but also for the actions of their students. Second, instructors desire to cooperate with and uphold or even elevate the standards of nursing care delivered in the clinical agencies in which students have patient experience. The opportunity for future clinical experience for students depends upon that. Third, instructors usually are conscientious practitioners themselves, and expect students to measure up to their own standard of excellence. Fourth, part of the Florence Nightengale pledge and the pledge of the International Nurses Association state that nurses will assist patients to the best of their ability to achieve a maximum level of health. Instructors strive to live up to these standards. Instructors may take a maternalistic view of students though and rate them higher than students rate themselves. Instructors may give students the benefit of the doubt in their ratings and this would tend to make their ratings higher than students' self-assessment. In rating their students very

Table 10
Average Score on 18 Questions
Instructor Ratings

Rating	Frequency	Adjusted Frequency Percentage	Cummulative Frequency Percentage
1.00	8	20.5	20.5
1.05	2	5.1	25.6
1.06	1	2.6	28.2
1.11	1	2.6	30.8
1.16	1	2.6	33.3
1.17	3	7.7	41.0
1.21	1	2.6	43.6
1.23	2	5.1	48.7
1.26	2	5.1	53.8
1.31	1	2.6	56.4
1.32	2	5.1	61.5
1.44	2	5.1	66.7
1.47	2	5.1	71.8
1.56	1	2.6	74.4
1.58	1	2.6	76.9
1.61	1	2.6	79.5
1.78	1	2.6	82.1
1.94	1	2.6	84.6
2.00	1	2.6	87.2
2.06	1	2.6	89.7
2.22	1	2.6	92.3
2.56	1	2.6	94.9
2.67	1	2.6	97.4
3.00	1	2.6	100.0

Mean=1.433 Standard Error=.080 Standard Deviation=.502

positively, these instructors showed they were pleased with the performance of their students.

The Patient Sample and Ratings

During the two-week data collection period, the 39 students cared for 158 patients. Questionnaires were distributed to 128 of the patients. Seventy-seven completed the forms for a return rate of 60.2%. All of the returned scales were usable. The return rate of instruments compares favorably with the return rates of other studies (Watson, 1979). The number of patient ratings per student varied from one to four (Table 11). Patients who were discharged before the end of their two days with a student were instructed to leave their answer sheets at the nursing desk. These forms were not included in the study and account for the loss of a number of potential raters. The results of this loss to the study are impossible to ascertain.

Table 11
Number of Patient Ratings Per Student

Students			
Number	Percentage	Ratings/Student	Number of Ratings
14	35.89	1	14
15	38.46	2	30
7	17.94	3	21
3	7.69	4	12
39	100.00	Totals	77

Of the 77 patients who completed ratings, 49 were males and 28 were females (Appendix F). Fourteen students were evaluated by both males and females; 25 were evaluated by patients of one sex. Sex of the students was not included as a reportable variable on patient or student information sheets. Watson (1979) also did not investigate the interactive effect of patient and student sex on the ratings.

The patients were rather equally divided between the age groups of 40 and below and those 41 and over. Thirty-seven (48.1%) patients were 40 and younger, 40 (51.9%) were 41 or older. The largest single group of patients in this study were orthopedic patients, many of whom were in the younger age group. The majority of patients (66.7%) were over 40.

The educational preparation of the patient participants fell within the lower categories. Forty-six of the respondents (59.7%) had only a high school education or less. Thirty-one (40.3%) had some college or a college degree. Watson (1979) had similar findings for the lower educational levels.

Thirteen patients (16.8%) had never been hospitalized before. Thirty-one (40.3%) had been hospitalized one or two times. Thirty-three (42.9%) had been hospitalized three times or more.

Diagnoses showed a variation involving all the major body systems. The most frequently reported diagnoses were orthopedic problems, followed by gastrointestional, cardiovascular and genitourinary disorders. No distinction was made as to conditions requiring surgery. Watson (1979) had found no significant difference in the ratings of surgical and non-surgical patients.

Forty-nine patients answered 18 of the items on the questionnaire; 75 of the 77 answered item 19. Again, the ratings were very high; patients rating students 74.9% very positively (Table 2), with a mean rating of 1.319 (Table 12, p. 46). On item 19, patients gave students 86.7% very positive with a mean of 1.200 (Table 4) They reported being very satisfied with the care they received from nursing students.

While the highly positive ratings from patients are desirable, several factors may contribute to these beside the quality of nursing student care. Each student cared for no more than two patients on each clinical day, allowing the students to respond promptly to patient needs and to focus their attention and energy on providing individualized, comprehensive nursing care. Such individualized care would cause patients to feel satisfied with care received. Second, patients sometimes take a maternal or paternal attitude toward students and this attitude could cause high ratings. Third, patients sometimes respond to a generalized perception of the nurse as a helper. Fourth, items on the scale were unidirectional, and since there was no way to control for response set, this unidirection could have inflated the ratings. Fifth, the role of evaluators for patients is a new role and they may not have been comfortable with this responsibility or sure of the expectations for them. Sixth, students may have performed better for the patients knowing that their performance was being evaluated.

Item Analysis of the Ratings

Several interesting trends are evident on examination of responses to individual items. Item 7, answers when I call or checks on me

Table 11
Patient Rating of Students
Average of All Patients

Rating	Frequency	Adjusted Frequency Percentage	Cummulative Frequency Percentage
1.00	16	20.8	20.8
1.05	2	2.6	23.4
1.07	5	6.5	29.9
1.13	1	1.3	31.2
1.14	5	6.5	37.7
1.15	4	5.2	42.9
1.18	2	2.6	45.5
1.21	3	3.9	49.4
1.27	4	5.2	54.5
1.28	2	2.6	57.1
1.29	2	2.6	59.7
1.32	1	1.3	61.0
1.36	3	3.9	64.9
1.42	3	3.9	68.8
1.44	3	3.9	72.7
1.50	6	7.8	80.5
1.55	2	2.6	83.1
1.61	3	3.9	87.0
1.67	3	3.9	90.9
1.68	5	6.5	97.4
1.89	2	2.6	100.0

Mean=1.288 Standard Error=.028 Standard Deviation=.249

frequently, shows 89.6% of the patients and 89.7% of students gave very positive ratings (Table 2). Students were very conscientious about this and felt positive about their efforts to meet the patients' needs immediately. Instructors were less positive on this giving only 79.5% very positive responses. Overall very positive ratings were 85.4%, showing that all groups agree that students check on their patients frequently and answer them promptly. This contributes strongly to satisfaction with care.

Item 8, keeps me informed ahead of time what will be done during my hospital stay, received lower ratings from all three groups than did a number of other items. Students rated themselves 61.1% very positive, instructors gave 61.5% very positive ratings and patients gave 61.9% very positive ratings (Table 2). The groups were very similar in their ratings, showing that all feel this is an area that needs improvement. Not only are the consumers saying they want to know, the care givers are saying they should know. An informed patient is more likely to be a cooperative and satisfied patient (Sparrow, 1978). Since at least 61.0% of each of the groups rated this item very positive, students did seem to be doing an adequate job of keeping patients informed.

Item 9, often asks me or recognizes when I am in pain and uncomfortable, also showed students gave themselves a high rating of 78.9% very positive (Table 2). Students felt good about their ability to perceive and respond to patient comfort needs. However, patients gave only 65.8% very positive ratings. So student response to discomfort is not as rapid as patients would like nor as efficient as students think it is. This discrepancy is rather commonly seen in care patients receive in health care facilities.

Responses for item 11, explains type and purpose of my diet, were the lowest ratings students received on the scale (Table 2). Students give themselves only 34.3% very positive ratings, instructors rated them 31.4% very positive, and patients rated them 49.1% very positive. Overall ratings were 32.3% very positive, with 31 respondents in the three groups giving no response to item 11. Several reasons may account for these low ratings. First, students may not feel prepared to give diet information and thus may avoid the issue much of the time. Second, the short time students are with patients may be insufficient for them to deal with the diet issue. Third, one of the major differences in associate degree and baccalaureate nursing programs is the emphasis on technical skills in the associate degree program versus the teaching/planning/community emphasis in baccalaureate programs. Possibly this difference in educational emphasis showed up here, particularly since this difference did not occur in the study by Watson (1979) of baccalaureate nursing students.

Item 12, explains what I need to know to care for myself at home, was the item that received the second lowest ratings from all three groups (Table 2). Students rated themselves 52.8% very positive, instructors gave 51.5% very positive ratings, and patients gave 52.8% very positive ratings. Item 12 was among the few items on which patients gave negative ratings. A number of patients marked this item not applicable and did not give a rating on it. It appears students were not as proficient in this area as patients, students or instructors desired. Students may have felt inadequate to deal with instructions for patient self-care at home, and may therefore have avoided the issue.

Or they may have approached the issue, but have done so inadequately. Time may not have permitted their dwelling on home care. Another possible explanation is that this again is an area emphasized in baccalaureate programs but not in associate degree programs. The stated purpose of the latter is to educate skilled bedside nurses with technical skills rather than to develop teaching or management skills. Although the three groups gave students lower ratings on this than other items except for diet teaching, students still rated themsleves more positively than did either instructors or patients. This was also true on item 11.

Item 13, provides me with a safe, orderly, comfortable environment, is a measure of a basic nursing principle taught to all students at the very beginning of their nursing education. Students apparently learn the lesson well and implement it, since 82.3% respondents rated this very positive. Students rated themselves 87.2% very positive in this area, instructors rated them 76.9% very positive, and patients rated 88.0% very positive. Again, instructors were more critical of students' performance than the other two groups.

Item 15, allows me to do as much for myself as I can and am allowed to do, shows some differences of opinion among the three groups (Table 2). Students gave 82.1% very positive ratings, patients gave 90.3% very positive, and instructors gave 71.8% very positive ratings. Apparently patients feel they have sufficient opportunity to exercise self-care in spite of the fact that both students and instructors feel patients do not. Perhaps this is an area where the nurse's role of patient advocate showed up in extremes.

One indicator of success is an individual's level of self-confidence. Many investigators (Mitchell, 1979; Panos, 1979; Williams and Muehl, 1970) reported that as the level of self-confidence goes up, so does the level of achievement. Looking at ratings on item 17, is self-confident and knows what he/she is doing, would suggest that these nursing students are and will be successful. Overall very positive ratings were 63.3%. Students rated themselves 97.4% very positive or positive in this area, with instructors and patients giving very positive or positive ratings 87.2% and 93.5% respectively. It is interesting that patients and instructors perceive students as being less confident than students report they feel. Students must feel confident of their own ability before they can project their self-confidence to others. All three groups perceive students as self-confident, a necessary ingredient of success in any endeavor. A self-confident nurse can cause a patient to feel well cared for and satisfied with nursing care.

Item 18, handles equipment and carries out manual procedures with skill, shows great variation in ratings among the three groups. Students rated themselves 41.0% very positive, instructors rated students 56.4% very positive, and patients rated them 76.0% very positive (Table 2). This leads to several suggestions of causation. The ability to perform technical and manual skills varies among students. This may be due to differences in work experiences, in practice opportunities in laboratory and clinical settings, in coordination of students, and/or the supervisory techniques of various instructors. This may also be a result of the time limits on clinical experiences that plague all nursing education programs. Nursing and hospital administration as well as students and faculty decry the lack of clinical experiences students receive. But with the present crucial need for both well grounded theory and high level technical skills, nursing education strains to provide a well balanced blend of academic and practical nursing experiences.

CHAPTER IV

IMPLICATIONS, LIMITATIONS AND SUMMARY

This study concludes with a discussion of implications of the findings for use of the Patient Rating Scale, suggestions for further research, limitations of the study and a summary of the study.

Implications of Findings for Use of the Scale

The Patient Rating Scale was used to provide feedback from patients to faculty and students about the quality of care delivered by associate degree nursing students in one NLN-approved program. The instrument can provide students with one source of information about the quality of their patient care.

This study supports Watson's findings that the scale is a valid measure of patient satisfaction with nursing care. It is a good indicator that consumer concerns are being considered in the delivery of nursing care. With satisfaction being one indicator of quality of care, the patient information may be used as an additional source of data on which to make decisions about the quality of nursing care.

Nursing instructors may use the scale as an additional source of information in making judgments about student clinical performance. Valencia faculty found that patients gave more specific comments to them about students' nursing care when they used the scale and the instructor discussed student clinical performance with them. Faculties could use the information provided by the Rating Scale as part of the formative and summative evaluation of nursing programs. They could use the scale to determine how well the stated philosophy, objectives and purposes of the program are being incorporated into the program. Patient evaluations with the scale could be used as an additional source of data on which to make judgments about the quality of students' clinical performance.

In educating nursing students, the scale would be a reminder that the ultimate goal for nursing students is not their own objectives, nor those of their instructors or the school, but the rendering of good patient care, as measured by patient satisfaction.

The scale could also be used to help educate patients to some expected behaviors of health care providers, possibly increasing their ability to discriminate between levels of performance. It also could strengthen the consumer's position in the delivery of health care, providing patients with a tool to voice their opinions.

The administration procedure also provided feedback on the use of the Rating Scale. Obtaining a patient sample for this study was too time consuming for the regular use of the scale for evaluation. If such an instrument were incorporated into program evaluation, a logical approach would be to collect the information from patients using the Rating Scale for a specified and limited period of time. The period should allow enough time to collect data on each student from several patients. The data also should be gathered early in the academic year to allow student participants and faculty to benefit from the ratings.

Patients were generally happy to participate in the evaluation of students. The hospitals were eager for feedback, as were students and instructors. Such studies seem to point the way to getting more consumer input into the health care delivery system, something long overdue. Perhaps some of the tension between patients and members of the health team could be decreased if patients had more opportunity to say what really met their needs and if their suggestions were well received and acted on positively.

Suggestions for Further Research

Replication of this study is recommended to increase the validity and reliability of the scale itself. Increasing the number of subjects itself would be particularly desirable. The Patient Rating Scale developed by Watson is now available but needs further testing to establish its credibility.

The ratings on items 11 and 12, which indicated that this group of associate degree nursing students were not meeting the needs of patients for diet and self-care information, show the need for additional research in these areas in particular. Comparison studies need to be made between baccalaureate and associate degree nursing students. Such research could help to answer the question, "Are the ratings on those two items a result of a difference between associate degree and baccalaureate nursing education, or are they an artifact of this study?"

The findings relative to the inadequacies felt by students and perceived by both instructors and patients in technical skills call for additional investigation. Are students actually lacking in technical skills or do they just feel unsure of themselves? Is there sufficient emphasis on technical skills in nursing education? How could students be made to accept more responsibility for this?

Further testing and revision of the scale needs to be done to make possible the use of the instrument with the three subscales as designed by Watson. This would make possible more specific information about the clinical performance of nursing students. At present it provides only a general feedback about patient satisfaction and is not a diagnostic tool for nursing student clinical performance.

Correlations of ratings on this scale with nursing GPA might be used to predict State Board scores for students. Obviously, more data on the significance of correlations between GPA and the rating scale need to be gathered through additional research before this can be done. Further comparisons might be made among nursing GPA, patient ratings, State Board scores and employer ratings during the first year of nursing practice.

This study found that the patient variables of age and educational level were not significantly related to patient ratings of students (Table 7). However, the number of hospitalizations was significantly related to patient satisfaction in this study. Patients with three or more hospitalizations rated student performance higher than patients with two or fewer hospitalizations. All three of these variables were significantly related to patient satisfaction in studies conducted by Watson (1979) and others. Hence, further studies are needed to establish the true significance of these variables to patient reports of satisfaction with nursing care. If these variables are related to patients' ratings of their care, then Watson's scale should be sensitive to these differences.

Further correlations between GPA and student clinical performance should be done to establish the reliability of the findings in this present study that a high GPA begets higher patient ratings. This information surely has great potential as motivation for students in classroom learning. They are more likely to see the classroom as preparation for the clinical situation if a direct correlation between classroom grades and clinical performance can be shown.

Limitations

As suggested in Chapter I, this study has several limitations. First, the small sample size limits the generalizability of findings. In order to generalize to all nursing students, ratings are needed on a larger sample of students from different levels of students within a program and from students in different types of nursing programs. Since patient satisfaction is important to nurses, this seems a worthwhile goal. Other indicators of satisfaction, such as confidence in other health care providers, especially physicians, and "certainty of diagnosis" (Morgan, 1974) have shown some relationship to satisfaction with care. Therefore other indicators of satisfaction with hospital experience may provide additional insights into patients' perceptions of their total hospital experience.

This scale was used only on adult, general medical-surgical units in an urban hospital setting. Therefore results cannot be generalized to specialized units such as pediatrics, psychiatry, obstetrics, or critical care areas, nor to hospitals in a rural setting.

Another limitation is the fact that approximately half of the patients cared for by nursing students during the data collection period did not complete the rating scale. Little is known about this group and its potential effects on the ratings. Some of these patients were judged by the instructors to be too ill to participate; others were excluded because instructors believed the patients were not mentally able to complete the evaluation scale. However, most of the patient sample was lost due to discharge before the end of the data collection period. Using a variety of evaluation protocols would allow more patients to participate than using only a self-report paper-and-pencil instrument.

A further limitation is that patients who had been hospitalized before far outnumbered patients who had never before been hospitalized. Only 13 of the 77 patients in this sample were experiencing their first hospitalization. This limited number of patients with single admissions does not allow for adequate analysis of this variable. Morgan (1974) reported that patients who had many previous hospitalizations were more satisfied with care received than patients admitted for the first time. Differences in the ratings of patients who had two or fewer hospitalizations and those who had three or more were not significant. A study that includes a more representative sample of both patients with multiple hospitalizations and patients hospitalized for the first time may produce greater variability among ratings. Studies could also be done to determine why the number of hospitalizations affects patient satisfaction with nursing care.

Summary

The major purpose of this study was to use the Patient Rating Scale developed by Watson to ascertain the satisfaction patients feel about the care delivered to them by associate degree nursing students at one community college. Other purposes were to test the scale as a measure of patient satisfaction with nursing care and to determine if GPA influenced ratings of nursing students' clinical performance. Since few scales are available for this purpose, it seemed important to validate further Watson's scale. The scale appears to be a valid measure of overall patient satisfaction with nursing care. This outcome is important to nursing.

The overwhelming finding of the study was the positive assessment of student clinical performance by patients, instructors and the students themselves. Students with higher nursing GPA received higher ratings from both instructors and patients than students with lower nursing GPA received. Student self-ratings were not significantly related to GPA. Overall patient satisfaction with care as measured by item 19 was also high and correlated positively with GPA for instructor and patient ratings, but again no significant correlation was found between nursing GPA and student ratings. Student self-assessments were more closely correlated to patient than to instructor ratings.

The patient variables of age, educational level and number of hospitalizations were examined for significance in influencing patient ratings. No significance was found for age and educational level. The number of hospitalizations was significantly related. Patients with three or more hospitalizations rated higher their satisfaction with nursing student clinical performance than those with two or fewer hospitalizations.

Item analysis of the Rating Scale revealed that students were rated lowest by all three groups on items relating to diet and self-care instructions at home. Students rated themselves low on the ability to perform technical skills. These findings need to be substantiated with further studies. Both associate degree and baccalaureate students should be studied.

Approximately half of each group contacted became part of the sample. Ratings were obtained from 77 patients, 39 senior nursing students, and six nursing instructors. The number of patient ratings per student varied from one to four. Each student did a self-assessment and was also rated by the clinical instructor. None of the respondents reported difficulty with the instrument and all Rating Scales collected were usable. Patients were generally enthusiastic about doing the ratings. Combining other data collection methods with this paper-and-pencil format would yield a wider sample of patients since this format excludes many possible participants.

APPENDIX A

PATIENT RATING SCALE

Patient Rating Scale

	Listens attentively when I talk. Conveys warmth and interest in me and my concerns.		Usually listens when I talk but does not appear too interested in what I have to say.		Usually disinterested in what I have to say. Often seems not to hear what I say.
1.	☐	☐	☐	☐	☐
	Maintains a kind, gentle and friendly manner with me. Accepts me as I am.		Is polite but seems too busy and hurried to spend time with me.		Is abrupt in manner towards me. Criticizes my appearance and behavior
2.	☐	☐	☐	☐	☐
	Gives me recognition and praise for any progress I have made. Gives me explanations and reassurance when needed.		Acknowledges my progress but does not seem to be that interested in what I am doing		Unaware of any progress or accomplishments I have made. Comments only on setbacks or mistakes.
3.	☐	☐	☐	☐	☐
	Is considerate of my family and friends when they visit. Includes my family in discussions and decisions affecting us both.		Talks to my family and friends when they visit but mainly about own activities and problems.		Ignores my family and friends when they are present. Excludes them from discussions and decisions affecting us.
4.	☐	☐	☐	☐	☐

	Does not pressure me to talk when I do not wish to talk. Allows me time alone when I need it.		Allows me to be silent when I do not wish to talk but seems to be unaware of when I need to be alone.		Makes me feel like I should talk even though I don't want to talk. Tells me how I should feel
5.	☐	☐	☐	☐	☐
	Responds quickly to my request for help or assistance. Follows through on promises to me.		Usually responds rapidly to my request for help but sometimes is slow or forgets to return.		Slow to respond to my request for help. Makes promises but usually does not carry them out.
6.	☐	☐	☐	☐	☐
	Answers when I call or checks on me frequently. Is available when needed.		Will come when requested, but usually not around otherwise.		Disturbs me frequently for no apparent reason then not available when needed.
7.	☐	☐	☐	☐	☐
	Keeps me informed ahead of time what will be done during my hospital stay. Explains activities, procedures, and tests so I can be prepared.		Tells me just before a test or procedure is to be done what is going to happen giving me only limited time to prepare.		Does not tell me what is happening or what is scheduled for me so I can be prepared.
8.	☐	☐	☐	☐	☐

	Often asks me or recognizes when I am in pain and uncomfortable and acts to provide relief.		Does not ask but when told I am uncomfortable and in pain will act to provide relief		Unaware of my discomfort. Ignores or is slow to respond to my request for relief from discomfort.
9.	☐	☐	☐	☐	☐
	Allows me to decide when I will do my daily activities. Allows me to proceed at my own pace without showing annoyance.		Asks me when I would like to do my daily activities but usually ends up going ahead with what is most convenient for self.		Tells me when everything is to be done. Rushes me through most of my procedures and care.
10.	☐	☐	☐	☐	☐
	Explains type and purpose of my diet. Encourages me to ask questions about my diet.		Tells me only the name of the diet I am on. Does not explain the purpose. Will answer questions I ask.		Does not explain my diet. Does not or is unable to answer questions I ask.
11.	☐	☐	☐	☐	☐
	Explains what I need to know to care for myself at home. Encourages my questions. Checks to see that I understand and can perform skills.		Gives me a list of things to do when I get home but does not check on my skill or understanding. Answers questions I ask.		Does not spend time teaching me what I need to know to go home.
12.	☐	☐	☐	☐	☐

	Provides me with a safe, orderly, comfortable environment. Provides privacy and enough equipment for bathing and personal care.		Will clean up my bed area if I ask. Occasionally needs to be reminded of my privacy needs.		Leaves obstacles and clutter in the way of my moving around. Does not insure my privacy for personal care.
13.	☐	☐	☐	☐	☐
	Allows me enough rest. Avoids tiring me but encourages activity and exercise. Explains the need for activity and allows me to help plan my activity.		Allows me to rest as needed. Provides opportunities for exercise and activity. Does not explain the purpose of activity and need for rest.		Either pushes me to exercise not allowing for rest or lets me remain in bed at a low level of activity not explaining the need for both.
14.	☐	☐	☐	☐	☐
	Allows me to do as much for myself as I can and am allowed to do. Allows me to be as independent as possible. Is willing to help me as I need it.		Allows me to start doing things for myself but usually finishes up for me even though I can and would like to do things for myself.		Does not allow me to do things for myself. Takes over whenever I try to do something on my own even though I should be doing it myself.
15.	☐	☐	☐	☐	☐
	Usually well organized and knows what to do next. Completes jobs begun in a manner that is comfortable and convenient for me.		Somewhat disorganized but occasionally forgets needed equipment or needs help to complete a job.		Is poorly organized. Begins a job but seldom completes it before going off somewhere else.
16.	☐	☐	☐	☐	☐

	Is self confident and knows what he/she is doing. Able to focus on my concerns and needs.		Needs assistance to begin care but then proceeds on own very well.		Appears to be unsure of self. Preoccupied by own problems and concerns.
17.	☐	☐	☐	☐	☐
	Handles equipment and carries out manual procedures with skill.		Somewhat hesitant when handling equipment but seems to know how the skill should be done.		Frequently fumbles with equipment and is unsure of how to proceed with a manual skill.
18.	☐	☐	☐	☐	☐
	I am completely satisfied with the nursing care I received. It met my needs.		I thought the nursing care I received was adequate, but it was not all that I expected.		I am not pleased at all with the nursing care I received. It did not meet my needs.
19.	☐	☐	☐	☐	☐

APPENDIX B

INSTRUCTIONS TO THE STUDENT

Instructions to the Student

I am studying the value of patient input in providing additional data to evaluate nursing students' clinical performance. Traditionally, evaluation in the clinical area is the responsibility of the nursing instructor based primarily on personal observations of their students' performance. There have been few attempts to systematically obtain input from patients. Yet, patients have greater opportunity to directly observe students in the clinical area, and as recipients of the care, are in a unique position to provide feedback on that care. A nurse developed a rating scale which I would like the patients who you care for to use as a structured means of sharing feedback on that care. The information obtained will be analyzed for its usefulness in providing additional data on which to evaluate nursing students' clinical performance over and above the methods currently used. I would like to collect data from all the patients who you care for during the next two weeks. Each patient you are assigned to care for will be approached individually on Tuesday during your clinical experience to obtain their consent to participate. They will be given the Rating Scale and oriented to its use. During the next two days they will be observing the care given to them by you. At the end of the second day, the scales will be picked up. This same format will be used during the second week. The data collected will be shared with the nursing faculty but in a general way as a summary of what all patients are saying about the students. The data will not be used in determining your course grade. No student will be identified individually in reporting the results. Thank you for your help.

APPENDIX C

STUDENT DEMOGRAPHIC INFORMATION FORM

Student Demographic Information

Student # _______________

Age _____________________

Theory grade in current nursing course(s) _______

____

Nursing Course Grades

_____	NUR 1140C	Fundamentals of Nursing
_____	NUR 1111C	Maternity Nursing
_____	NUR 1310	Psychiatric Nursing
_____	NUR 1210	Fundamentals of the Nursing Process
_____	NUR 1210C	Introduction to Medical-Surgical Nursing
_____	NUR 2120C	Nursing Care of Children
_____	NUR 2221C	Nursing Care of Adults with Motor and Sensory Deprivation
_____	NUR 2222C	Nursing Care of Adults with Problems Related to Maintenance of Nutrition, Elimination and Regulatory Mechanism
_____	NUR 2240C	Nursing Care of Adults with Problems of Inadequate Oxygenation
_____	NUR 2430	Team Leadership

APPENDIX D

INSTRUCTIONS TO PATIENT

Instructions to Patient

During the next two days, you will be cared for by a nursing student from Valencia Community College here in Orlando. The Valencia Community College nursing faculty are trying to get information from the patients our nursing students care for on the quality of that care. The information will be used to help us better judge how well the Valencia Community College nursing students are doing. We would like your help in getting this information. I have here a rating scale which describes behaviors you might see in the nursing students. We would appreciate you filling this scale out on the student who will be caring for you these next two days. The student will not see your individual responses, and the information you give us will help us tremendously in evaluating our nursing program and improving the care given to patients. Filling out the scale will not affect the care you are to receive in any way. Your participation is voluntary, and you may withdraw at any time. We will leave the scale with you for the next two days, and you may fill it out at your convenience. We will be back Wednesday afternoon to pick up the scale. If you are discharged before then, just leave the scale with the nursing staff here.

We know that many things may influence how we perceive what is happening to us and around us. The information from these forms will give us data on some of those variables and will help us interpret all the information we will be receiving. Do you have any questions?

This form was designed to help you tell the nursing faculty about the nursing care you have been receiving from the nursing students of Valencia Community College. Each of the nineteen lines on the form contains three statements that might be made by a patient describing the nursing care, and above each line are five boxes. Place a checkmark (✓) in the box on each line that most closely describes your feeling about the nursing student who has been taking care of you.

Please check one of the boxes on each of the nineteen lines. The purpose of this form is to help us understand better how patients feel about our nursing care. Your responses will be kept confidential and will not be shown to anybody but the person doing the study. Your responses will not be used to grade students. We will be reporting what we have learned from all the patients in a general way to the faculty and students of the Valencia Community College nursing program. The information will help us improve our care to patients.

Thank you for your help.

APPENDIX E

PATIENT DEMOGRAPHIC INFORMATION FORM

Patient Demographic Information

1. Sex __________ Male __________ Female

2. Age __________ 18-24
   __________ 25-40
   __________ 41-59
   __________ 60 and over

3. Occupation ____

4. Education __________ Grade school
   __________ Some high school
   __________ High school diploma
   __________ Some college
   __________ Some graduate schooling
   __________ Graduate degree

5. Number of previous hospitalizations __________ 0
   __________ 1-2
   __________ 3-5
   __________ Over 5

6. Diagnosis(es) ____

7. Student # __________

APPENDIX F

DEMOGRAPHIC DATA FOR PATIENTS

Demographic Data for Patients
(N=77)

	n	Percentage
Sex		
Male	49	63.6
Female	28	36.4
Age		
18-24	20	25.6
25-40	19	24.4
41-59	25	32.1
60 and over	13	16.7
Occupation		
Craftsman/Artisan	3	3.9
Professional/Managerial	12	7.6
Clerical/Sales	8	5.1
Laborer	12	7.6
Skilled/Technical	8	5.1
Student	8	5.1
Unemployed	2	2.6
Retired	14	8.9
Housewife	9	5.7
No response	1	3.9
Education		
Grade school	3	3.9
Some high school	16	20.5
High school diploma	27	35.1
Some college	23	29.8
Some graduate schooling	3	3.9
Graduate degree	5	6.5
Number of Previous Hospitalizations		
0	13	16.7
1-2	32	41.0
3-5	16	20.8
Over 5	15	19.5
No response	1	3.9

Appendix F--continued

	n	Percentage
Diagnosis		
Cardiovascular	7	9.1
Orthopedic	42	54.5
Neurology	5	6.5
Dermatology	2	2.6
Genitourinary	6	7.8
Endocrine	4	5.2
Respiratory	2	2.6
Gastroenterology	7	9.1
No response	2	2.6

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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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